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INTRODUCTION

Wilhelm Reich developed his character-analytic vegetotherapy in Denmark and Norway between 1934 and 1936.

Whereas his fellow psycho-analysts worked with patients essentially by the analysis of the *contents* of their communications, Reich analysed in addition the form of the communication. This led him to a detailed study of muscle tone, posture, and patterns of respiration.

He found a disturbed pattern of breathing in all the patients he treated, and came to the conclusion that reduced inspiration or reduced expiration or both, was a central mechanism of neurotic repression.

By 1934 he had begun to counteract the dysfunctional breathing by a special style of massage and manipulation, and typically his clients released a range of repressed emotions. Emotional release was followed by more rhythmic respiration.

The autonomic nervous system has a strong influence both on respiratory rhythms and on the emotional balance of a person. In Germany this system is called the "vegetative" system, and Reich's term "vegeto-therapy" is derived from this.

Many modern forms of psychologically oriented therapy involving the body, including Gestalt therapy, bio-energetics, and primal therapy have been profoundly influenced by Reich.

Nearly all strong emotions - crying, anger, fear, and pleasure, involve increased breathing. So it is not surprising that if a person seeks to repress these emotions, breathing reduction is a central dynamic.

In Reich's work the therapist seeks to deepen his breathing beyond the level of the repression. In doing so he has to be sensitive to the natural rhythms of the breath-cycle, and to the thresholds of anxiety in the client. Reich warned that changing the patterns of a person's breathing was tantamount to emotional surgery, and should only be attempted by those experienced in his methods.

Inexperienced therapists trying to provoke a patient to deeper breathing can easily induce a hyper-ventilation crisis and not recognise it as such. Skill is required in this work since a patient with chronically reduced breathing may easily go into hyper-ventilation as a response to the therapeutic situation. The crisis is avoided either by careful *pacing* of the rate of respiratory change, or by the patient becoming more expressive, either muscularly, emotionally, or both.

The tension of the respiratory muscles are found in the pectorals, the inter-costals, and other muscles of the upper chest and back. Diaphragmatic tension is extremely frequent in many neurotic states. Since the diaphragm is attached to the spine, methods of mobilising the spine, and the psoas muscle are used as a principle means of opening the diaphragm. This work is not "exercises" and cannot be done mechanically. There is always an emotional *context* to the repression which needs to be sensed, elicited and resolved, before the dysfunctional patterns of breathing can be altered.

In looking at the breath-rhythms of a healthy baby or alive human being, the whole k will be seen to expand on the in-breath and deflate on the outbreath. There are four typical patterns of disturbance of this healthy rhythm:-

- (1) Over-inflation of the chest on inspiration with under-inflation of the abdomen.
- (2) Over-inflation of the abdomen on inspiration with under-inflation of the chest.
- (3) Under-inflation of both chest and abdomen on inspiration. The breathing is scarcely visible.
- (4) Under-inflation of the chest on expiration. The chest is hard and firm and cage-like. This pattern has been found to correlate closely with Type A characters prone to heart-attacks.
- (5) Under-deflation of the abdomen on expiration. The abdomen feels congested, tense, or spongy. This is associated with the "masochistic" temperament in Reichian characterology: the person who typically swallows down feelings and hold them in. Occasionally this is also linked to aerophagia - swallowing air, as well as feelings.
- (6) Forced expiration, with a tendency to establish some form of hyper-ventilation syndrome as discussed above.

These are the basic physiological choices which patients may show as deviations from motionally balanced and muscularly relaxed breathing-rhythm. In the remainder of this account I will try to present some of these patterns more in clinical setting, with more attention to the emotional context of the disturbed respiratory rhythm.

In her muscular-diagnostic test Nic Waal¹ has distinguished several varieties of breathing. She shows how in natural breathing the chest and the abdomen rise synchronously in inspiration and fall in expiration. The various ways in which this natural rhythm can be disturbed she describes as:-

- (1) Thoracic breathing, where respiration is mainly in the chest, and abdominal movements are kept to a minimum.
- (2) Abdominal breathing, where the respiration is mainly diaphragmatic so that the stomach wall can be seen to rise and fall, but chest movements are kept to a minimum.
- (3) Paradoxical breathing, where chest and abdomen both move, but are out of phase and unsynchronised.
- (4) Flutter-breathing, where there is a total lack of rhythm, and the breathing movements are irregular and uneven.

MUSCLE-BOUND BREATHING

The type of breathing that Reich described first was that which was characterised by stiffening of the chest muscles, and tightening of the rib cage, with a corresponding reduction of the free mobility of the diaphragm:

"The muscles that take part in the armouring of the chest are the intercostal muscles, the large chest muscles (pectoral muscles), the shoulder muscles (deltoid muscles) and the muscles on and between the shoulder blades. The expression of the chest armouring is essentially that of 'self-control and restraint'. The shoulders which are pulled back, literally express 'holding back'. Together with the neck armouring, the chest armouring expresses suppressed 'spite' and 'stiff-neckedness' (again to be taken literally). In the presence of an armour, the expression is that of 'immobility', or 'being unmoved'".²

In the "Expressive Language of the Living" from which this quotation is taken, Reich does not distinguish between the varied breathing styles shown by people with differing types of body armour, and differing types of experience and background. The kind of defence pattern described above is fairly specific to rigid patterns of armouring, where a marked stiffening and tenseness of the large muscle sheets of the body is a pronounced characteristic. The breathing of such people is *unfeeling* breathing. The breathing is reduced by the tensions, and it neither expresses strong emotion, nor responds easily to it. The breathing has a mechanical regularity to it, inspiration and expiration occur to predictable degrees, the breathing expands and contracts within the fixed limits imposed by the pressure of the rib cage and the abdominal wall.

The chronic expansion of the thorax creates a range of problems to which people with a tendency to rigid, muscularly armoured (in Lowen's sense) bodies are particularly prone. Reich includes amongst them "a tendency to increased blood pressure, palpitations and anxiety, in severe cases of long standing also to enlargement of the heart. Various kinds of heart disease result either directly from the chronic expansion or indirectly as a result of the anxiety syndrome. Pulmonary emphysema is an immediate result of the chronic expansion of the thorax".³

Reich also points out how militarism everywhere makes use of the expression embodied in this kind of armouring. Mathias Alexander pointed out in his books on the posture of the body how the methods of physical education prevalent when he wrote, with the stress on 'stomach in, shoulders back, chest out', re-inforced the body attitude of the stiff automaton responding to mechanical drill. Wilfred Barlow, a medical practitioner, of the Alexander method, wrote that in all the cases of coronary thrombosis that he had met "I have never yet seen a case in which the upper chest was not markedly raised and over-controlled. The 'powerful' tycoon impression is often accompanied by the blown-up, over-filled chest".⁴

INTESTINAL BREATHING

Reich also describes a form of armouring centred in abdominal pressure:

"Patients complain of an intolerable 'pressure' in the stomach, or of a girdle which 'restricts'. Others have a certain spot in the abdomen which is very sensitive. Everyone is afraid of getting punched in the belly. This fear becomes the centre of very rich phantasies. Others have the feeling that 'there is something in the belly that can't get out'; 'it feels like a dinner plate in my belly'; 'my belly is dead'; 'I have to hold on to my belly', etc. Most of the

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phantasies of small children about pregnancy and childbirth centre around the vegetative sensations in their abdomen".³

Now there are specific ways of using the gut as a way of suppressing feeling. The gut can be constricted by abdominal pressure, by contraction of the anal sphincter, by 'swallowing' down of feelings, and by tension in the diaphragm, which the upper part of the alimentary canal must pass through to get from chest to abdomen. Reich discusses this in relation to the energetics of vomiting:

"In many cases of diaphragmatic block there is, together with the inability to vomit, more or less constant nausea. There can be no doubt that the so-called 'nervous' stomach disorders are the direct result of the armouring in this region. Vomiting is a biological expressive movement the function of which achieves exactly what it 'expresses': convulsive expulsion of body contents. It is based on a peristaltic movement of stomach and oesophagus in the opposite direction of its normal function, that is towards the mouth (anti-peristalsis). The gag reflex dissolves the armouring of the diaphragmatic segment quickly and radically. Vomiting is accompanied by a convulsion of the body, a rapid folding in the epigastrium, with a forward jerk of the head as well as pelvis. In the colic of infants, vomiting is accompanied by diarrhoea. Energetically speaking strong waves of excitation run from the middle of the body upwards and downwards toward mouth and anus. . . . These convulsions go with deep expiration".⁷

A child who is made to feel ashamed or guilty about the expulsion of the body contents learns to swallow down bad tastes as well as bad feelings, rather than spit them out; and to inhibit the peristaltic movements of the colon. He often develops a specific pattern of breathing which accompanies and supports the anti-peristaltic pattern. We could speak of intestinal breathing. I noticed it in a patient who, when she breathed out, filled up and pressurised the abdomen, even while her chest relaxed and moved downwards. This is an example of the paradoxical breathing, mentioned by Nic Waal; "the directions of movement in the thorax and the abdomen are in this case in opposition to each other. 'When the chest goes out the abdomen goes in' and vice versa. The abdomen is pulled in during inspiration, and presses out under expiration, and the diaphragmatic movements are quite out of touch with the movements of the chest".¹

Such breathing was also independently described as 'paradoxical' by Lowen, who wrote: "In paradoxical breathing inspiration is produced by an upward movement rather than an outward one. . . . Thus the expansion of the chest is accompanied by a narrowing of the abdominal cavity. Sometimes one observes that the belly is sucked in during inspiration and let out in expiration".⁵

Lowen has reported on a related pattern in a masochistic patient: "When the patient attempted to make a deep expiration, as in a deep sigh, the chest relaxed, but the descending wave piled up into a hard knot in the middle of the abdomen. . . . It made me think of someone straining at stool. He looked as if he were trying to push something out against a resistance".⁶

We have here a pattern of breathing transferred to the respiratory system from the intestinal system, a breathing pattern that would be particularly expected in association with people exposed to nauseating situations that make them want to throw up (the 'poison' of paranoia) or with people exposed to situations of anal humiliation and disgust over abdominal contents (the morass of masochism).

BREATHING AS SUCKING

In the oral character Lowen describes the opposite of the inflated chest of the rigid character. "Marked muscular tension seems absent from the front of the body but this is only because of the *deflated condition of the chest and abdomen*".⁶ In contrast to the pattern just described, "the gag reflex is fairly easy to elicit. This may be due to early feeding disturbances with persistent tendencies to vomit".⁶ It is as though the oral defence is an acclimatisation to emptiness, "The chest is generally deflated, the belly is without turgor and feels *soft and empty to palpation*".⁶

The deflation of the oral body structure and personality characteristics, which Lowen has described so clearly, is found in the breathing pattern: We can recognise a specific type of oral breathing distinguished by the fear and reluctance to express greed. It is not that he is afraid of the sensation of air rushing into his lungs, like the patient of Mott quoted in Part I. It seems to be a learned attitude transferred from his suckling behaviour. The child learns to be disappointed and left feeling hungry not only in relation to food, but in relation to air. His experience that reaching out for what you want does not get you what you want, that you are left unfilled and uncharged, is learned in relation to the flow of milk from the mother, which is a flow he cannot regulate. When this is transferred to breathing, it means that such a person starves himself of air, he is afraid to gulp it in and suck it down. When working on the breathing inhibition of people who show this problem I find it helpful to cup my hands one each side of the neck. The extra charge helps to draw the air through. As a person begins to open to a stronger flow of air and to be greedy for it, I can sometimes feel the flow of energy filling up in the neck like a plant coming into turgor when it is watered. The oral attitudes of sucking nourishment from other people or from the substitutes provided by various additions, stem from the refusal to let nourishment rush in from the air, and the failure to become addicted to oxygen.

"Any disturbance in the function of sucking", Lowen wrote, "will have an immediate repercussion upon the function of breathing".⁵

BORN AND UNBORN BREATHING

Reich has described a very different breathing pattern in a case of schizophrenia that he treated; although this pattern also seems to be based on a reluctance to breathe in, its origins and dynamics are very different.

"I tried to approach her dysfunction of respiration. The problem was not, as in the armoured neurotic, to break down the armouring of the chest. *There seemed to be no armour*. The problem was how to make her draw in and expel air through the larynx. She began to struggle severely whenever I tried to bring about full respiration. I had the impression that the function of respiration was not stopped by any immobility due to armouring, but was inhibited as if by a *strong conscious effort*".⁷

Reich describes how one of the functions of this breathing inhibition is to cut off the vegetative currents moving in the body, and that his patient fought these "by not permitting the passage of air to and from the lungs". This presents an obvious paradox: if the schizophrenic refused to take in air she would die of anoxia, just as a person who takes in too little food may die of anorexia. But schizophrenics do not die from not breathing. The specific dynamic of this breathing seems to involve the minimising of the movements of the

breathing. In other words the intake of air and its expulsion does take place but is made as imperceptible as possible. It is interior, invisible breathing, as compared with the breathing of someone who confidently breathes out into the world. It is not that a person living in this way does not feel entitled to be nourished orally, and therefore reduces his demand on the air, like the situation described above. Imperceptible breathing is a denial not of the air, but of the breathing process itself which is the pre-requisite of life outside the womb. The schizophrenic breathing movements are a duplication as closely as it is possible to do so of the inactivity of the breathing apparatus inside the womb. The soft imperceptible breathing that Reich described is uterine 'respiration'. It is the breathing of someone reluctant or unable to be born. Because of the trans-marginal stress concept there may well be some ambivalence found: thus Lowen describes an attack of depersonalisation in relation to the breathing which happened to a patient of his, in these words: "I would sometimes get the strange feeling that I had no control over my breathing. The thoughts came that if I should suddenly stop breathing I could not start again. I seemed to be outside my body looking at it as if it wasn't me. I had feelings of weakness and dizziness, and I felt I was going to die. Then I would scream and collapse and the feelings would slowly pass away. It was awfully frightening".⁶

The scream of fear which led the sense of depersonalisation to go away is in effect a cry of birth. It brings the depersonalised person back to his body to some degree. The fear that one will stop breathing causes a gasp of air to rush in, whereas the depersonalised state is identified with an emotional attitude of non-breathing, of being unborn. Breathing vigorously for a schizoid person may arouse sensations of dying through drowning. Lowen explains this as follows:

"Opening the throat wide to breathe evoked feelings of drowning in several patients. One patient reported this sensation on a number of occasions. Yet the patient could not find any incident in his memory which could give rise to such an experience. The logical interpretation was that the feeling of drowning represented his reaction to a flood of tears and sadness which welled up in his throat when its tensions were relaxed. In the same way, the choking sensations commonly reported by patients could be interpreted as the "choking off" of these overwhelming feelings of sadness. But the feeling of drowning makes one wonder about a possible association with intrauterine existence, where the foetus floats in a sea of fluid. It is now known that the foetus makes respiratory movements in utero from about the seventh month onward. These are not functionally meaningful. However, if a uterine spasm were to cut off the flow of oxygenated blood to the placenta for a significant time, it is considered that these tentative respiratory movements could become real attempts to breathe. In this situation, the feeling of drowning would result from the flow of amniotic fluid into the foetal throat. This is pure speculation, but the possibility of such intrauterine experiences cannot be ruled out".⁵

Another form of schizoid breathing pattern described by Lowen appears to be the opposite of that shown by Reich's patient, and by the patient above. It is a situation where a person immobilises the breathing around the *inbreath*. "This kind of schizophrenic respiration", Lowen writes, "has an emotional sign. If you duplicate it in your self (*inflate your chest and pull in your belly*) you will hear a gasp as air enters your lungs. It is not difficult to recognise this as an expression of fright. The schizophrenic breathes as if he were in a state of terror".⁶

If this gasp, once taken in, is let out imperceptibly, then the expression of fear is frozen and intuned. The schizophrenic breathes like a man who plays dead on a battle-field and who will be shot if he betrays he is alive through his breathing movements. He can breathe but he must not be seen to breathe. The hysterical breathing attitude shows the opposite tendency: at all costs he must be seen to breathe. Breathing at least proves he is alive and out of the womb, but it is anxious panicky breathing, the breathing of someone who only just made it. Anxiety means constriction, and hysterical breathing is constricted breathing in which the breathing struggles to assert itself.

"Let us imagine", Reich wrote, "that one is frightened or in anticipation of great danger. Instinctively one will draw in one's breath and remain in this attitude. As one cannot continue to do this one will soon breathe out again. However, expiration will be incomplete and shallow; one does not breathe out completely in one breath, but in fractions, in steps, as it were. . . . What is the function of this attitude of 'shallow respiration'? If we look at the position of the inner organs and their relation to the solar plexus, we see immediately what we are dealing with. In fright one involuntarily breathes in; as for instance in drowning, where this very inspiration leads to death".³

Reich goes on to describe how children learn to fight anxiety states by restricting their breathing, and suppressing the anxious feelings. If they succeed, the resulting pattern of affect-block and rigid holding leads to the muscle-bound thoracic block already described. The hysterical body pattern copes with stress by expressing some of the anxiety symptoms and learning to manipulate the environment through them. The breathing pattern is close to what Nic Waal described as 'flutter-breathing', and it leads to a sensation of being short of breath. This is how Freud's patient Katherina answered his question 'what is it you suffer from?':

"I get so out of breath. Not always. But sometimes it catches me so that I think I shall suffocate".

Freud comments: "This did not, at first sight, sound like a nervous symptom. But soon it occurred to me that probably it was only a description that stood for an anxiety attack: she was choosing shortness of breath out of the complex of sensations arising from anxiety and laying undue stress on that single factor".⁷

The conversation between Freud and Katherina goes on as follows:

"Sit down here. What is it like when you get 'out of breath'?"

"It comes over me all at once. First of all it's like something pressing on my eyes. My head gets so heavy, there's a dreadful buzzing, and I feel so giddy that I almost fall over. Then there's something crushing my chest so that I can't get my breath".

"And you don't notice anything in your throat?"

"My throat's squeezed together as though I were going to choke".

"Does anything else happen in your head?"

"Yes there's a hammering, enough to burst it".

"And don't you feel at all frightened while this is going on?"

"I always think I'm going to die. I'm brave as a rule and go about everywhere by myself, into the cellar and all over the mountain. But on a day when that happens I don't dare to go anywhere. I think all the time someone's standing behind me and going to catch hold of me all at once".⁷

This gives a lot of insight into the transition between hysterical and schizoid breathing patterns. When she chokes and cannot get her breath the head pressure builds. Reich describes how "if the attitude of anxious anticipation is maintained for some time, a pressure in the forehead appears. I have had several patients in whom it was not possible to eliminate the pressure in the forehead until I discovered their attitude of anxious anticipation in the chest musculature".³ The hysterical tendency however, is to abreact some of the panic, to come out of the sense of choking into the flutter breathing, flirting with dying but always demonstrating a racy aliveness. The hysteric breathes with the hesitant panicky breath of a baby that had a difficult birth struggle.

I am not suggesting that we can rigidly classify styles of breathing and allocate them mechanically to specific character patterns. People have unique experiences which lead to all gradations of colouration by differing character tendencies and bodily attitudes. Styles of breathing shade into each other, and even polar extremes can exist in the same person as they cross the margin of stress, under fluctuating conditions of anxiety or tension. But looking on patterns of breathing in terms of uterine and birth experience, intestinal conflicts, and muscular boxing in, seems to me to increase the understanding of some of the dynamics we see when we work with people who struggle with the tensions and guilts and existential crises, of letting out or taking in air.

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The baby at birth comes from a fluid medium where all movements are weightless. When the waters break and the child begins to descend the birth canal, he is open to his first experience of gravity, though supine positions in childbirth reduce the assistance that gravity can give to the child's descent.

Life in the womb is mostly in a position of roundedness and curvature; flexor attitudes predominate, consistent with the fact that the child is wrapped in a small space. The limbs are flexed, the back is curved, the chin inclines towards the chest: the foetal position is often spontaneously adopted in sleep, when people often curl up to conserve warmth and maximise comfort and the sense of enclosure.

The flexor attitude is in some way associated with the *dependence* of the young infant. His hand shows the clinging reflex - strong enough for him to be lifted up so that he can support his own weight against gravity by the strength of closure. His legs are flexed in a position adapted to being held: in infant monkeys the flexion of the legs may assist the position of holding to the mother.

Any muscle has a certain tonus, the level of which can vary between extremes of rigidity, or limpness, around some hypothetical 'norm'. Clearly a different level of tonus is required for sleep, as is required for normal wakefulness, and a different level again for emergency functioning. Some people live their waking lives with the kind of tonus level that would be more appropriate for sleep: they are over-relaxed, and ill-equipped to deal with stress situations. Others may even sleep with a body tension level that functions at the emergency level. Feldekrais, in his book on the body and mature behaviour, (1) defines healthy tonus as the minimum level required to maintain a normal erect posture against the stress of gravity.

The developing child acclimatises to gravity slowly. As long as he is held, nursed, cuddled, he has the security of a basically foetal posture, and is insulated from gravity. But the body gradually learns to extend against gravity: almost all of the muscles that work against gravity, and support the body in sitting and standing, are extensor muscles. The child begins to unfold against gravity with the tonic neck reflex which lifts the head from the prone position and enables the child to orientate his vision and face the world. The spine learns to extend from the head downwards, control of the head preceding control of the arms, then the lower trunk control, permitting sitting, and finally control of the legs, allowing the child to stand erect in the world for the first time.

Learning to stand erect, involving a natural level of tonus in the extensor muscles of the spine, neck and legs, induces two curves in the back, the lumbar and cervical curves, at the base and apex of the trunk respectively. At the neck and shoulder end of the body is the attachment for the arms, at the lumbar and pelvic end are the legs. Unnecessary postural tension, it has been found, in any part of the body, produces compensatory tensions in most parts of the overall anti-gravity musculature.

Extensor muscles, required for standing, are the basis of independence, just as flexor muscles, required for curling up and clinging, are the basis of dependence.

In locomotor movements of any kind, whether it is walking, running, kicking, or swimming, an alternation of flexor and extensor movements is involved. Pulsatile waves of

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